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Supreme Court, U.S.
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No. 95-1729

IN THE SUPREME COURT OF THE UNITED STATES OCTOBER TERM, 1995

ROSE V. FORREST,
IN HER CAPACITY AS SECRETARY,
LOUISIANA DEPARTMENT OF HEALTH AND HOSPITALS,

Petitioner

v.

MYRTLE W. BLANCHARD AND PATRICE A. DUMAS, *et al.*,
Respondents

On Petition for A Writ of Certiorari
To The United States Court of Appeals
For The Fifth Circuit

MEMORANDUM IN OPPOSITION TO PETITION FOR A WRIT OF CERTIORARI

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21 pp

QUESTIONS PRESENTED

The sole Question Presented by the subject Petition for Certiorari which is not completely frivolous is more accurately stated as follows:

Whether the Court of Appeals for the Fifth Circuit correctly interpreted 42 U.S.C. §§ 1396a(a)(34) and (a)(10) to require petitioner to modify the Louisiana Medicaid procedure for coverage of medical care, supplies and services received during the retroactive coverage period which have been paid for by the recipient, where the current procedure provides coverage only if the provider first *voluntarily* refunds to the recipient any payments previously received, and then submits a claim for payment to Medicaid at Medicaid's generally lower rates.

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STATUTES AND REGULATIONS

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42 U.S.C. §1396a(a)(10) ..... *passim*

STATUTES AND REGULATIONS INVOLVED

In addition to 42 U.S.C. §1396a(a)(34), this case involves 42 U.S.C.§1396a(a)(10). These statutory provisions are reprinted at Appendices A and B, respectively, *infra*.

COUNTER STATEMENT OF THE CASE

Petitioner's Statement improperly asserts that Louisiana's policy on retroactive Medicaid coverage of bills which have been paid during the three-month retroactive coverage period and while an application for Medicaid is pending is "included in the Louisiana State Plan" and "has been approved by HCFA as being in compliance with Medicaid statutes and regulations." (Pet. 4). There is no support in the record for this claim, and in fact it is inaccurate. The "State Plan" Louisiana submits to HCFA includes an assertion that retroactive Medicaid coverage is provided, but does not include a description of the manner in which such coverage is provided.

Petitioner's Statement also fails to acknowledge the fact that Louisiana's system relies on voluntary provider refunds and that, as the court of appeals below stated, "[b]ecause Medicaid rates are usually much lower than the rates providers charge private patients, Medicaid providers in Louisiana have a disincentive to provide voluntary refunds to patients determined to be Medicaid-eligible after the services or supplies were furnished." Pet. App. a9.

REASONS FOR DENYING THE WRIT

The petition for a writ of certiorari should be denied for several related reasons. The court of appeals correctly applied federal law and there is no division of authority among the federal courts on the question presented. Moreover, although the relief awarded by the district court, and affirmed by the court of appeals, is indisputably important to the plaintiffs whose Medicaid benefits had been wrongfully denied, this case does not present a narrow issue of statutory interpretation, not an important issue of federal law.

I. THE DECISION OF THE COURT OF APPEALS IS CORRECT AND CREATES NO SPLIT IN LOWER COURT AUTHORITY.

A. The Court of Appeals Correctly Interpreted 42 U.S.C. §1396a(a)(34) and 42 U.S.C. §1396a(a)(10).

42 U.S.C. §1396a(a)(34) mandates that:

> [I]n the case of any individual who has been determined to be eligible for medical assistance under the plan, such assistance will be made available to him for care and services included under the plan and furnished in or after the third month before the month in which he made application...for such assistance if such individual was (or on application would have been) eligible for such assistance at the time such care and services were furnished. (Emphasis added)

Petitioner admits that "§1396a(a)(34) was intended to benefit applicants who were unaware of the availability of medical assistance or were unable to apply for assistance because of the exigent nature of their illness and subsequent medical care." Pet. 8. She nevertheless contends that this benefit is "available" even if it is conditioned on the largesse of their

medical providers. The court of appeals rejected this strained interpretation of the concept of availability. In analyzing §1396a(a)(34), the court stated:

> In sum, federal law requires state Medicaid plans to make available medical assistance during the retroactive coverage period. Under the federal statute and regulations, a Medicaid recipient must meet three requirements to obtain retroactive medical assistance: (1) medical services or supplies covered under the Medicaid plan must have been furnished; (2) during the three months prior to the month in which the recipient filed his Medicaid application; and (3) the recipient must have been eligible for Medicaid at the time the services or supplies were furnished. For Medicaid applicants who pay the provider at the time of service, the Louisiana policy adds a fourth requirement - that the medical provider first voluntarily refund payments made by the Medicaid applicant, and then submit a claim to LDHH for repayment at the lower Medicaid rate. Undoubtedly, few medical providers seeking to maximize their profits will volunteer such charity, as evidenced by the experiences of [respondents] Blanchard and Dumas.

Pet. App. 9a-10a (footnote omitted).

Petitioner has also completely ignored 42 U.S.C. §1396a(a)(10), a separate statutory requirement of the Medicaid program upon which the court of appeals also relied in reaching its holding. This Section, generally referred to as the "comparability requirement," requires that "the medical assistance made available to any individual ... shall not be less in amount, duration or scope than the medical assistance made available to any other [covered] individual..." App. A, attached hereto. The court of appeals found that:

> Under Louisiana's policy, Medicaid applicants who fail to pay their medical bills incurred during the retroactive period receive

> a greater amount of medical assistance than Medicaid applicants who privately pay for medical supplies or services during the retroactive coverage period. This unequal treatment violates the requirement of 42 U.S.C. §1396a(a)(10) . . .

Pet. App. 10a-11a.

Nor should any weight be given to petitioner's contention that HCFA has not found Louisiana's policy to be in violation of federal statutes and regulations. As discussed in the Counterstatement of the Case, *supra* at 1, there is no evidence in the record that HCFA has been informed about or reviewed the mechanics of Louisiana's retroactive coverage policy. In any event, even if HCFA had condoned this policy, that would not insulate it from court review for compliance with the Medicaid statute.

B. Summary Judgment was Properly Granted.

Petitioner asserts that the court of appeals erred in affirming the district court's grant of partial summary judgment "when genuine issues of material fact remained." Even if this assertion were accurate, which it is not, it would not be a reason for granting the writ of certiorari. Rule 10 of the Supreme Court Rules.

The court of appeals noted that "[a]lthough LDHH [Louisiana Department of Health and Hospitals] asserts that genuine issues of material fact exist, it fails to point out to this court a single disputed fact relevant to the question whether Louisiana's retroactive coverage policy complies with the requirements of the federal Medicaid statute." Pet. App. 12a. This

comment applies with equal force to the petition for certiorari. In lieu of relevant facts, petitioner advances a rambling discussion of miscellaneous considerations concerning whether her policy is "fair" and whether it violates the equal protection clause of the Fourteenth Amendment to the U.S. Constitution. However, as the court of appeals noted, "the district court's grant of summary judgment did not rest upon the Equal Protection Clause," and the "State's Medicaid plan need not only be fair and equitable, it must comply with federal statutes and regulations, " citing Wilder v. Virginia Hosp. Ass'n, 496 U.S. 498, 502, 110 S.Ct. 2510, 2513-14, 110 L.Ed.2d 455 (1990). Pet. App. at 12a.[1]

II. THIS CASE PRESENTS NO IMPORTANT POINT OF FEDERAL LAW THAT SHOULD BE SETTLED BY THIS COURT.

The court of appeals below held that petitioner's mechanism for providing retroactive Medicaid coverage to individuals who have paid bills entitled to such coverage fails to

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[1]It was for this reason too that the court of appeals rejected as irrelevant Petitioner's assertion that "Louisiana has taken pains to assure that all applicants are aware that bills for medical services provided in the three months prior to the month of application, if paid, are not coverable by Medicaid, without a refund from the provider." Pet. 11. This claim is irrelevant for yet another reason: the awareness that Louisiana Medicaid supposedly fosters would be of little value to an applicant. If, for example, the applicant needs a prescription filled during the retroactive coverage period, he will pay to get it filled even if he has to forego other basic necessities and then learns, as the named plaintiffs did, that the pharmacy does not make refunds after Medicaid eligibility is established. Moreover, contrary to petitioner's assertion here, the documents she relies on are in fact completely silent regarding the possibility of coverage if the provider voluntarily refunds payment. All these documents do is tell recipients that they cannot be reimbursed by Medicaid for bills they have paid, thus causing them to believe that they are out of luck with respect to such bills.

comply with the requirements of federal law, and that therefore a different mechanism must be used to make such coverage truly available. Petitioner has conceded throughout this litigation that the Louisiana Department of Health and Hospitals is required to afford such coverage to Medicaid recipients. Although of considerable concern to the respondents here, who have been wrongfully denied Medicaid coverage, the question of which mechanisms can be used to make such coverage available does not raise an important issue of federal law.

In an attempt to portray this case as one worthy of review, petitioner has presented three arguments, all of which are both inaccurate and beside the point. First, petitioner asserts that "the court of appeals in this matter has greatly increased the reach of the federal Health Care Financing Authority (HCFA) at a time when all the political trends, both nationally and at the state levels, are in the direction of reducing federal intrusion in the individual state operations of the Medicaid program." Pet. 6-7. Whatever political trends may be, the federal-state Medicaid partnership remains intact. So long as Louisiana is a party to that partnership, it must abide by the terms of the federal Medicaid statute. Wilder v. Virginia Hosp. Ass'n, *supra*.

Petitioner's second and third contentions relate to the two alternative remedies identified by the district court. Before discussing these concerns, it should be noted that the court of appeals correctly stated that the district court's order "does not limit LDHH to consideration of its two suggested remedies." Pet. App. 14a. Respondents have, for

example, suggested to petitioner a third mechanism. This is a type of "pass-through mechanism" under which providers do not refund payments to recipients, but verify for the agency the services provided and the patients' payments. Once the claim is substantiated, payment can then be "passed through" the provider to the recipient.

According to petitioner, the first of the remedies suggested by the district court -- requiring providers to make refunds to patients and then submit to Medicaid for payment at Medicaid rates -- violates providers' freedom to determine which Medicaid patients they are willing to treat, and will therefore drive them from the program. The court of appeals properly rejected petitioner's concern about providers' freedom to choose whom they will treat both because requiring providers to make refunds is not the only option open to petitioner and because a refund-and-submit requirement does not mandate that providers treat anyone they have not already chosen to treat. All that is at issue is whether the provider will be paid at a private pay rate rather than the Medicaid rate. As the court of appeals recognized, the "right" to payment at private pay rates is one Medicaid providers voluntarily abandon when they choose to participate in the Medicaid program, and "this suggested remedy would affect only those medical providers who have already elected to participate in the Medicaid program, as only their services would be 'covered' under the Medicaid plan. See 42 U.S.C. §1396a(a)(34); 42 C.F.R.§ 435.914(a)." Pet. App.14a. [2] Under defendant's

[2]Providers who participate in the program are by definition willing not only to accept the Medicaid rate instead of their private charges, but also to prepare the necessary paperwork and

policy on the other hand, needy Medicaid recipients cannot, as a practical matter, obtain retroactive coverage, and are therefore deprived of the full Medicaid coverage they are entitled to for such services.

Moreover, even if petitioner's unsubstantiated claim that requiring mandatory refunds would drive providers from the program were accepted as accurate, this concern could not justify allowing petitioner to disregard the requirements of 42 U.S.C. § 1396a. Wilder v. Virginia Hospital Ass'n, *supra*. Congress has determined recipients' rights, and it is inappropriate to undermine that determination by giving providers unchecked authority to prevent recipients from receiving the full retroactive coverage to which they are entitled under 42 U.S.C.§§ 1396a(a)(34) and (10). Petitioner's concern about provider dropout would be an issue for Congress, not a justification for depriving recipients of their statutory rights. While some recipients may be inconvenienced if the pool of participating providers were to decrease, this possibility cannot be recognized as a legitimate basis for completely depriving other recipients of Medicaid coverage to which they are entitled by law.

Petitioner's third contention is that the other remedy suggested by the district court -- direct payment by the department to recipients -- is "fraught with ample opportunity for fraud." Pet. 8. The solution to this concern is to simply require adequate documentation from the recipient and/or provider. Petitioner has not shown below why this process would be

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live with the delay in payment for services to Medicaid patients.

readily subject to fraud if adequate documentation were required, and, in any event, this concern has no bearing on the court of appeals' entirely proper interpretation of the Medicaid statute.

CONCLUSION

For the foregoing reasons, the petition for a writ of certiorari should be denied.

Respectfully submitted,

NEW ORLEANS LEGAL ASSISTANCE CORP.
Attorneys for Respondents

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APPENDIX A

§ 1396a. State plans for medical assistance

(a) Contents

A State plan for medical assistance must—

* * * * * * * * *

(34) provide that in the case of any individual who has been determined to be eligible for medical assistance under the plan, such assistance will be made available to him for care and services included under the plan and furnished in or after the third month before the month in which he made application (or application was made on his behalf in the case of a deceased individual) for such assistance if such individual was (or upon application would have been) eligible for such assistance at the time such care and services were furnished;

§ 1396a. State plans for medical assistance

(a) Contents

A State plan for medical assistance must—

* * * * * * *

(10) provide—

(A) for making medical assistance available, including at least the care and services listed in paragraphs (1) through (5), (17) and (21) of section 1396d(a) of this title, to—

* * * * * * *

(B) that the medical assistance made available to any individual described in subparagraph (A)—

(i) shall not be less in amount, duration, or scope than the medical assistance made available to any other such individual, and

(ii) shall not be less in amount, duration, or scope than the medical assistance made available to individuals not described in subparagraph (A);

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v.

MYRTLE W. BLANCHARD AND PATRICE A. DUMAS, *et al.*,
Respondents

Petition for A Writ of Certiorari
To The United States Court of Appeals
For The Fifth Circuit

PROOF OF SERVICE

I hereby certify that I served one copy of the foregoing Memorandum in Opposition to Petition for Writ of Certiorari on all parties required to be served by depositing the same in a U. S. mailbox on the 16 day of May, 1996, addressed to the following counsel of record for the Petitioner as required by Rule 29.3: Mary O'Brien, Bureau of Legal Services, Louisiana Department of Health and Hospitals, P.O. Box 3836, Baton Rouge, LA 70821-3836.

Mark A. Moreau

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MOTION FOR LEAVE TO PROCEED IN FORMA PAUPERIS

Pursuant to 28 U.S.C. § 1915, respondents Myrtle Blanchard and Patrice Dumas respectfully move for leave to proceed in forma pauperis in that they are unable to pay the costs of these proceedings due to their indigency as evidenced by the attached affidavits.

Respectfully submitted,
NEW ORLEANS LEGAL ASSISTANCE CORP.
Attorneys for Respondents
BY: Mark A. Moreau

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Petition for A Writ of Certiorari
To The United States Court of Appeals
For The Fifth Circuit

AFFIDAVIT IN SUPPORT OF MOTION FOR LEAVE TO
PROCEED IN FORMA PAUPERIS

State of Louisiana

Parish of Orleans

I, Patrice Dumas, being duly sworn, depose and say that I am one of the two named Respondents in the above-entitled case; that in support of my motion for leave to proceed in forma pauperis, I state that because of my poverty I am unable to pay the costs of said proceeding or to give security therefor; that I believe I am entitled to redress in this litigation; and that the decision of the court of appeals below should not be reviewed or disturbed by this court.

I further swear that the responses which I have made to the questions and instructions below relating to my ability to pay the cost of defending against the petition for certiorari are

true.

1. Are you presently employed?

   Yes, I work part-time, 30 hours per week, at a rate of $5.50 per hour at the Metairie Bank & Trust Company.

2. Have you received within the past twelve months any income from a business, profession or other form of self-employment, or in the form of rent payments, interest, dividends, or other source?

   No.

3. Do you own any cash or checking or savings account?

   The balance in my checking account is approximately $25. I do not have cash or a savings account.

4. Do you own any real estate, stocks, bonds, notes, automobiles or other valuable property (excluding ordinary household furnishings and clothing)?

   Yes, I own a house and a 1989 Plymouth Voyager.

5. List the persons who are dependent upon you for support and state your relationship to those persons.

   Deshaun Dumas, son
   Andy Harry, son

I understand that a false statement or answer to any questions in this affidavit will subject me to penalties for perjury.

Patrice A. Dumas
PATRICE A. DUMAS

SUBSCRIBED AND SWORN TO
before me this 25th day of
APRIL, 1996.

Mark A. Moreau
NOTARY PUBLIC

No. 95-1729

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AFFIDAVIT IN SUPPORT OF MOTION FOR LEAVE TO
PROCEED IN FORMA PAUPERIS

State of Louisiana

Parish of Orleans

I, Myrtle Blanchard, being duly sworn, depose and say that I am one of the two named Respondents in the above-entitled case; that in support of my motion for leave to proceed in forma pauperis, I state that because of my poverty I am unable to pay the costs of said proceeding or to give security therefor; that I believe I am entitled to redress in this litigation; and that the decision of the court of appeals below should not be reviewed or disturbed by this court.

I further swear that the responses which I have made to the questions and instructions

below relating to my ability to pay the cost of defending against the petition for certiorari are true.

1. Are you presently employed?

   No.

2. Have you received within the past twelve months any income from a business, profession or other form of self-employment, or in the form of rent payments, interest, dividends, or other source?

   No.

3. Do you own any cash or checking or savings account?

   The balance in my checking account is approximately $200. I do not have cash or a savings account.

4. Do you own any real estate, stocks, bonds, notes, automobiles or other valuable property (excluding ordinary household furnishings and clothing)?

   No.

5. List the persons who are dependent upon you for support and state your relationship to those persons.

   None.

I understand that a false statement or answer to any questions in this affidavit will subject me to penalties for perjury.

Myrtle Blanchard
MYRTLE BLANCHARD

SUBSCRIBED AND SWORN TO
before me this 17th day of
APRIL, 1996.

NOTARY PUBLIC

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Petition for A Writ of Certiorari
To The United States Court of Appeals
For The Fifth Circuit

PROOF OF SERVICE

I hereby certify that I served one copy of the foregoing Motion For Leave To Proceed In Forma Pauperis with supporting documentation by depositing same in a United States mailbox on the 10 day of May, 1996, addressed to the following counsel of record for the Petitioner as required by Rule 29.3: Mary O'Brien, Bureau of Legal Services, Louisiana Department of Health and Hospitals, P.O. Box 3836, Baton Rouge, LA 70821-3836.

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